

8348

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>St. Mary's Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colton's Point</b>			
				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>L.</b> Last <b>Amann</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1873</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frederick L. Amann</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Amann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>578-28-1674</b>		17. INFORMANT <b>Mary Elizabeth Amann</b> Address <b>Colton's Point, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1<sup>st</sup>, 1959</b> to <b>July 1<sup>st</sup>, 1959</b> , that I last saw the deceased alive on <b>July 1<sup>st</sup>, 1959</b> , and that death occurred at <b>11:20 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D.				ADDRESS (Street, city or town, state) <b>Leonardtwn</b> DATE SIGNED <b>1959</b>			
PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b> <b>Leonardtwn, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/4/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>		22d. LOCATION (City, town, or county) (State) <b>BUSHWOOD MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</b>				24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Colton's Point</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX AT BIRTH

RACE AT BIRTH

EDUCATION AT BIRTH

OCCUPATION AT BIRTH

RELIGION AT BIRTH

DATE OF DEATH

PLACE OF DEATH

8349

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ollen</b> Middle <b>Denning</b> Last <b>Barefoot</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1898</b>
9. AGE (In years last birthday) yrs. <b>60</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Westbrook Barefoot</b>		14. MOTHER'S MAIDEN NAME <b>Avey Tart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-16-5137</b>	
17. INFORMANT <b>Mrs Ruth H. Barefoot</b>		Address <b>California, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 8, 1954</b> to <b>July 17, 1959</b> , that I last saw the deceased alive on <b>July 13, 1959</b> , and that death occurred at <b>12:27 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7/13/59</b>			
ACTUAL SIGNATURE <b>P. J. Bean M. D.</b>		PHYSICIAN'S NAME (Type) <b>Great Mills, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 20 1959</b>	24b. REGISTRAR'S SIGNATURE <b>C. L. &amp; H. H. H.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 8350 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Enock</b> Middle <b>Archibald</b> Last <b>Bell</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30, 1875</b>	
9. AGE (In years last birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Park Hall, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Bell</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wise</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give branch or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Eleanor Gattton Bell</b> Address <b>Leonardtwn, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>421.4</b> <b>Chronic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Lymphocytic Leukemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 8, 1957</b> to <b>July 9, 1959</b> , that I last saw the deceased alive on <b>July 9, 1959</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>P. J. Bean M. D.</b>				ADDRESS (Street, city or town, state) <b>Great Mills Rd Leonardtown, Maryland</b>			
DATE SIGNED <b>July 14/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Medlays Neck, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 14 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED STATE DEPARTMENT OF HEALTH - CHICAGO, ILL.  
 22ND COMMUNICATE OF DEATH  
 NAME: [illegible]  
 SEX: [illegible]  
 AGE: [illegible]  
 RACE: [illegible]  
 BIRTH DATE: [illegible]  
 BIRTH PLACE: [illegible]  
 DEATH DATE: [illegible]  
 DEATH PLACE: [illegible]  
 CAUSE OF DEATH: [illegible]  
 REPORTED BY: [illegible]  
 SIGNATURE: [illegible]  
 DATE: [illegible]



8351

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>10 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Ellen</b> <b>Dykes</b>		4. DATE OF DEATH <b>July 18, 1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1959</b>	
9. AGE (In years last birthday) <b>10</b>		10. IF UNDER 1 YEAR <b>10</b> Months Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>		12. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>?</b>		16. MOTHER'S MAIDEN NAME <b>Nancy Dykes</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>		18. SOCIAL SECURITY NO. <b>-----</b>	
19. INFORMANT <b>Mother</b>		20. Address	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> <b>773.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24a. TIME OF INJURY Hour o. m. p. m. <b>19</b>		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24d. (City or town) (County) (State)	
25. I certify that I attended the deceased from <b>July 17, 1959</b> to <b>July 18, 1959</b> that I last saw the deceased alive on <b>July 17, 1959</b> and that death occurred at <b>3:40 PM</b> from the causes and on the date stated above		26. ADDRESS (Street, city or town, state) <b>Great Mills, Maryland</b>	
27. ACTUAL SIGNATURE <b>P.J. Bean</b> M.D.		28. DATE SIGNED <b>7/18/59</b>	
29. PHYSICIAN'S NAME (Type) <b>P.J. Bean M.D.</b>		30. <b>Great Mills, Maryland</b>	
31a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		31b. DATE THEREOF <b>7/19/59</b>	
31c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		31d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Md.</b>	
32. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>		33. REC'D BY REGISTRAR <b>Jul 20 '59</b>	
34. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>		35. REGISTRAR'S SIGNATURE	

2078161XV3

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology. The title is "The Effect of Temperature on the Growth of Bacteria". The objectives are to determine the effect of temperature on the growth of bacteria and to determine the optimum temperature for bacterial growth. The scope is to study the effect of temperature on the growth of bacteria in a laboratory setting. The methodology is to use a series of test tubes containing different temperatures of water and to observe the growth of bacteria in each tube.

2. The second part of the report is a detailed description of the results of the experiment. It includes a table of the data and a graph showing the relationship between temperature and bacterial growth. The data shows that bacterial growth is highest at 37°C and lowest at 4°C. The graph shows a bell-shaped curve with a peak at 37°C.

3. The third part of the report is a discussion of the results and a conclusion. The discussion explains the reasons for the results and compares them to previous studies. The conclusion states that the optimum temperature for bacterial growth is 37°C.

4. The fourth part of the report is a list of references. It includes the names of the authors and the titles of the books and articles that were used in the report.



## 8352 CERTIFICATE OF DEATH

08333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>GOLD</b> Last <b>FEIMSTER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin Gold</b>		14. MOTHER'S MAIDEN NAME <b>Frances Blanton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Lester L. Feimster - California, Md.</b>	
17. INFORMANT <b>Lester L. Feimster - California, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vaso-motor Collapse (Shock)</b> <b>902.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture Rt. Hip</b> DUE TO (c) <b>Long Standing Rheumatoid Arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>20 hours</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from Bed</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>11</b> p. m. <b>6 30</b> 19 <b>59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>California St Mary Md.</b>	
21. I certify that I attended the deceased from <b>6-30</b> , 19 <b>59</b> , to <b>7-1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-1-59</b> , 19____, and that death occurred at <b>2:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Lexington Park, Md.</b> DATE SIGNED <b>7/2/59</b>			
ACTUAL SIGNATURE <b>Wm. H. Patrick</b>		M.D. <b>Lexington Park, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. H. Patrick, MD</b>		<b>Lexington Park, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Shelby, North Carolina</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		ADDRESS <b>P.B. Robinson - Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARKANSAS STATE DEPARTMENT OF HEALTH—BIRMINGHAM, ALA.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item See: Birth Cert. et

8353

## CERTIFICATE OF DEATH

08334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN 1b <b>6hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bushwood</b> d. STREET ADDRESS <b>---</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cheryl</b> Middle <b>Ann</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 59</b>
9. AGE (In years last birthday) yrs <b>2</b>		IF UNDER 1 YEAR <b>17</b> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>***</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY: <b>EX U.S.A.</b>	
13. FATHER'S NAME <b>George L. Hall</b>		14. MOTHER'S MAIDEN NAME <b>Joanne Sievertson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George L. Hall</b>		Address <b>RiverSprings, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>475x</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 1959</b> to <b>July 2, 1959</b> , that I last saw the deceased alive on <b>July 2, 1959</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Joseph E. Gill</b> M.D.		ADDRESS (Street, city or town, state) <b>Leonardtown, Md.</b> DATE SIGNED <b>7/3/59</b>	
PHYSICIAN'S NAME (Type) <b>Joseph E. Gill M.D.</b>		<b>Leonardtown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	22d. LOCATION (City, town, or county) (State) <b>Bushwood, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

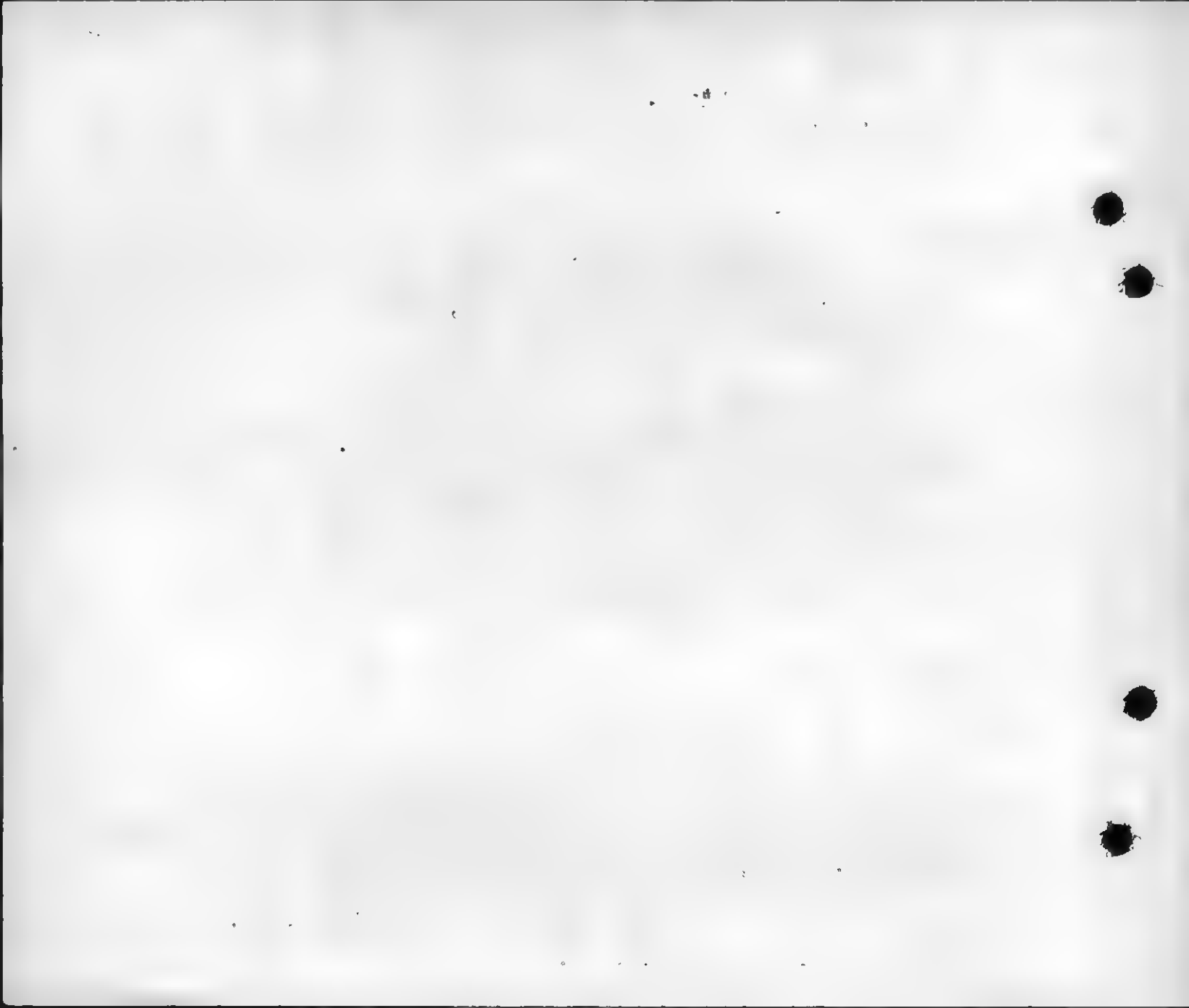
8354 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>		
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>			e. STREET ADDRESS <b>Rural</b>		
3. NAME OF DECEASED (Type or print) <b>Granville Vernon Hall</b>			4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 59</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1902</b>		9. AGE (in years last birthday) <b>57</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Henry Hall</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>719-16-3009</b>		17. INFORMANT <b>Granville G. Hall</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary accident</b> <b>420.1</b> DUE TO (b) <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <b>9-30 p.m. 7-19-59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>P. J. Bean, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/21/59</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>First Baptist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fairfax, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James C. Chinn - Arlington, Va.</b>		24a. REC'D BY REGISTRAR <b>JUL 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





Item 20 Film 245 7-20-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08336

8355 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN 1b <b>Leonardtwn</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Holland</b> Last <b>Herbert</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence C. Herbert</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Neale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>-----</b>	
17. INFORMANT <b>Mrs. Wm. Holley-</b>		Address <b>Leonardtwn, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> 903.0 DUE TO <b>Fracture of neck of femur (right) 9 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture of neck of femur (right) 9 days</b> DUE TO (c) <b>Fracture of neck of femur (right) 9 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral embolism</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>fell on floor at home while walking from bedroom to bathroom (this had happened frequently)</b>			
20b. TIME OF INJURY Month, Day, Year Hour <b>5</b> p. m. <b>July 3 1959</b>		20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>in home</b>		20e. (City or town) <b>Scotland St. Marys</b> (County) <b>Md.</b> (State)	
21. I certify that I attended the deceased from <b>July 2, 1959</b> , to <b>July 7 1959</b> , that I last saw the deceased alive on <b>July 6, 1959</b> , and that death occurred at <b>1:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Md.</b> DATE SIGNED <b>7/8/59</b>			
ACTUAL SIGNATURE <b>P.J. Bean</b> M.D.		Great Mills, Md.	
PHYSICIAN'S NAME (Type) <b>P.J. Bean, MD</b>		Great Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		22d. LOCATION (City, town, or county) <b>Leonardtwn, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 14 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

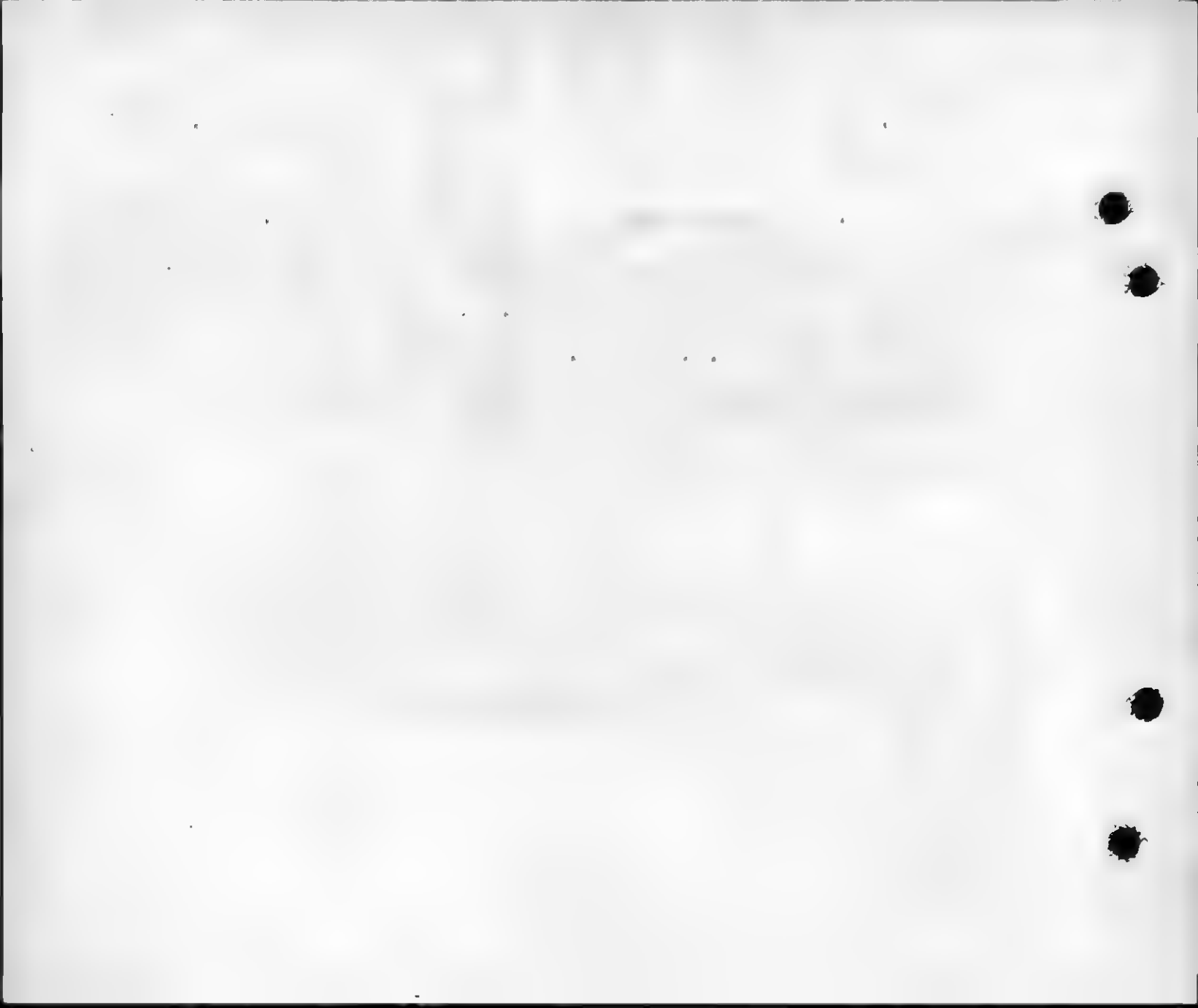
8356 Item 7 7/16/59 cap  
**CERTIFICATE OF DEATH**

08337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
		d. STREET ADDRESS <b>504 Enterprise Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Elmer</b> Last <b>Herbert</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1908</b>
9. AGE (In years last birthday) yrs. <b>51</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager 5&amp;10 store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>H.S. King Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C. North Carolina</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Estelle Goodwin (Mother)</b>		14. MOTHER'S MAIDEN NAME <b>Joseph Spencer Herbert (Father)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Army W.W.2</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Joseph S. Herbert, father,</b>		Address <b>437 Meadow Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331x</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>42 hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 8, 1959</b> to <b>July 9, 1959</b> that I last saw the deceased alive on <b>July 9, 1959</b> and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.			
ACTUAL <b>William Phillips</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>July 17, 1959</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>		ADDRESS <b>3331 Brehms Lane</b>	
24a. REC'D BY REGISTRAR <b>JUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8357 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>MD</b>		COUNTY <b>ST. MARY'S</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Morganza</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>PINEY POINT</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Hoyd</b> (Middle) <b>MARTIN</b> (Last) <b>Jordan</b>				(Month) <b>July</b> (Day) <b>20</b> (Year) <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 19 59 2 AM</b>	9. AGE last birthday <b>25</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jeremiah J. Jordan</b>				14. MOTHER'S MAIDEN NAME <b>Mauline E. Beiscoe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>MOTHER</b>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Cardiac arrest (ventricular septal defect - 3 years)</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Premature birth (months)</b>							
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 19, 1959</b> to <b>July 20, 1959</b> , that I last saw the deceased alive on <b>July 19, 1959</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city, town, state) <b>Great Mills Md</b>			
DATE SIGNED <b>7/21/59</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>7/22/59</b>		NAME OF CEMETERY OR CREMATORY <b>St. George's</b>		LOCATION (City, town, or county) (State) <b>Valley Lee, Md.</b>	
24. REC'D BY REGISTRAR <b>OCT 1 '59</b>		REGISTRAR'S SIGNATURE <b>C. L. &amp; K. R.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md</b>	

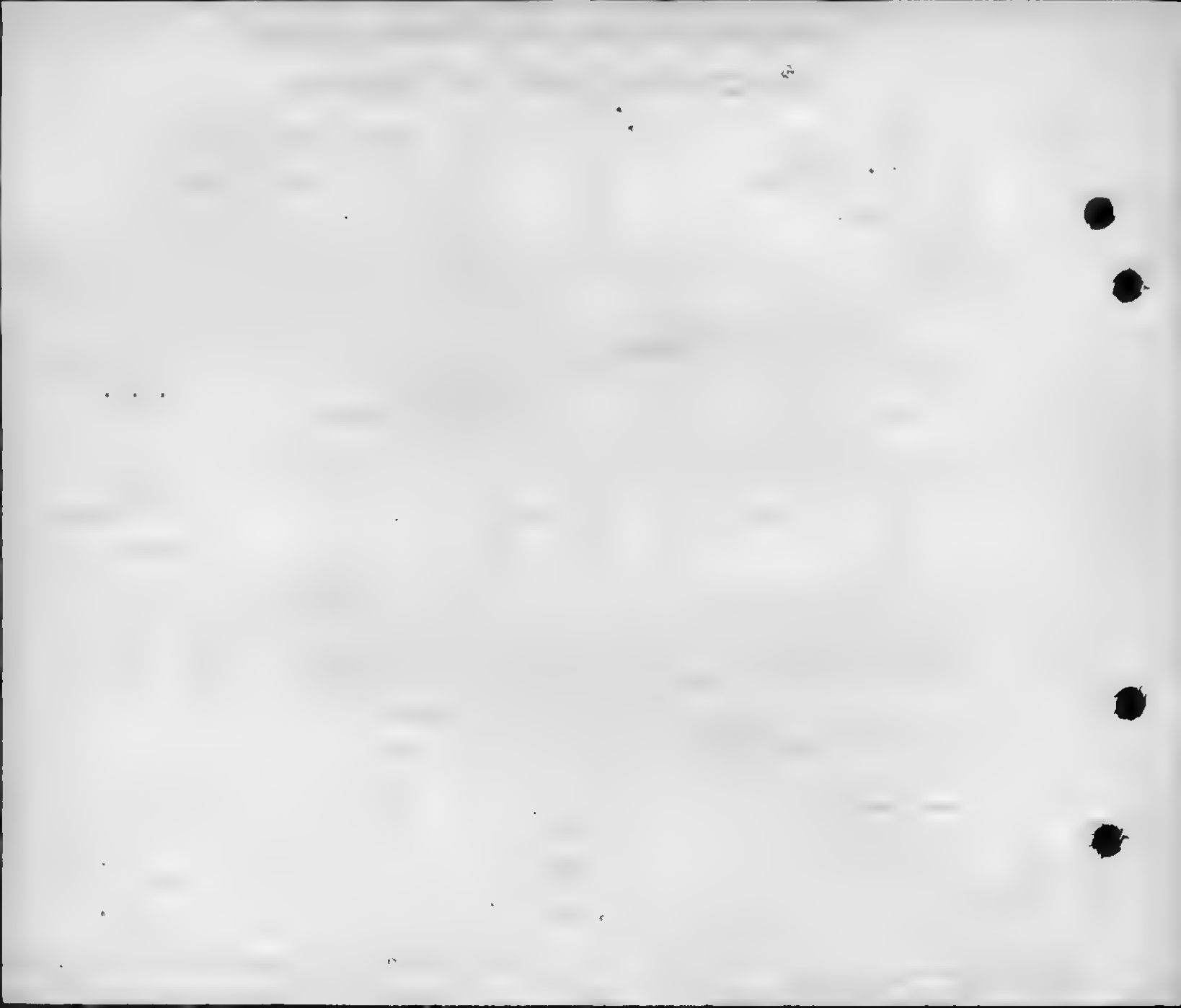
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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

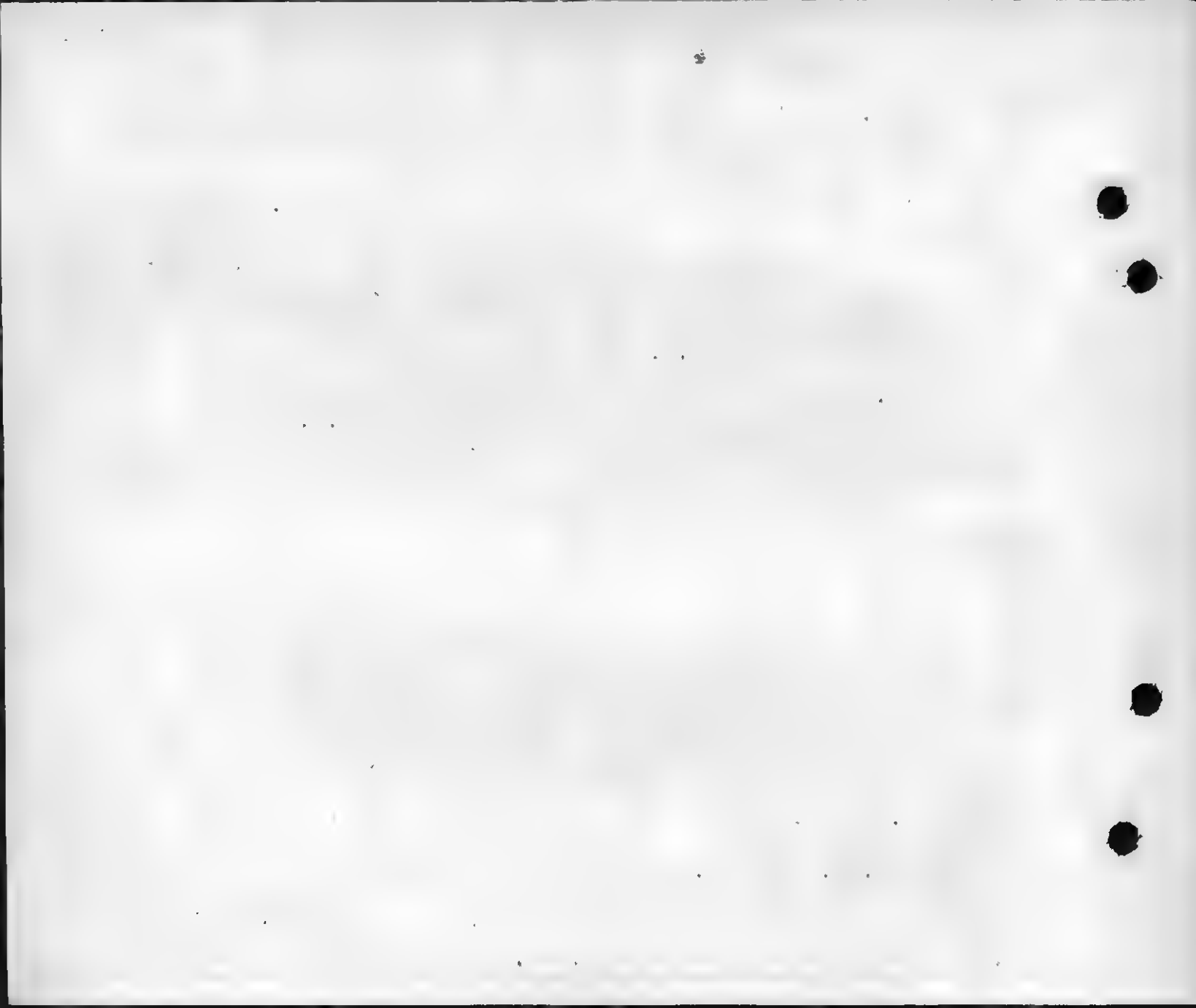




1 DEPUTY MEDICAL EXAMINER: is certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08338
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Rhode Island</b> b. COUNTY <b>Providence</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River, USNAS</b>			c. LENGTH OF STAY IN 1b <b>12 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Apponaug</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Officer's Quarters</b>					d. STREET ADDRESS <b>11 Clayton Rd.</b>					
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Gabriel</b> Last <b>KANE</b>					4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 November 1923</b>		9. AGE (In years last birthday) <b>35</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aviator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George V. Kane</b>					14. MOTHER'S MAIDEN NAME <b>Not obtainable</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1-42 to 7-59</b>					16. SOCIAL SECURITY NO. <b>061-18-1513</b>		17. INFORMANT <b>Official U.S. Navy Records, USNAS, Patuxent River, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis</b> DUE TO <b>470.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(Pending)</b> DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Natural causes</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .										
ACTUAL SIGNATURE <b>J. MILLER, LT MC USNR USNAS, Patuxent River, Maryland</b>					DATE SIGNED <b>7/6/59</b>					
EXAMINER'S NAME (Type) <b>WM. D. BOYD, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) <b>Apponaug, Rhode Island</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>					24a. REC'D BY REGISTRAR <b>JUL 10 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knott</b>			



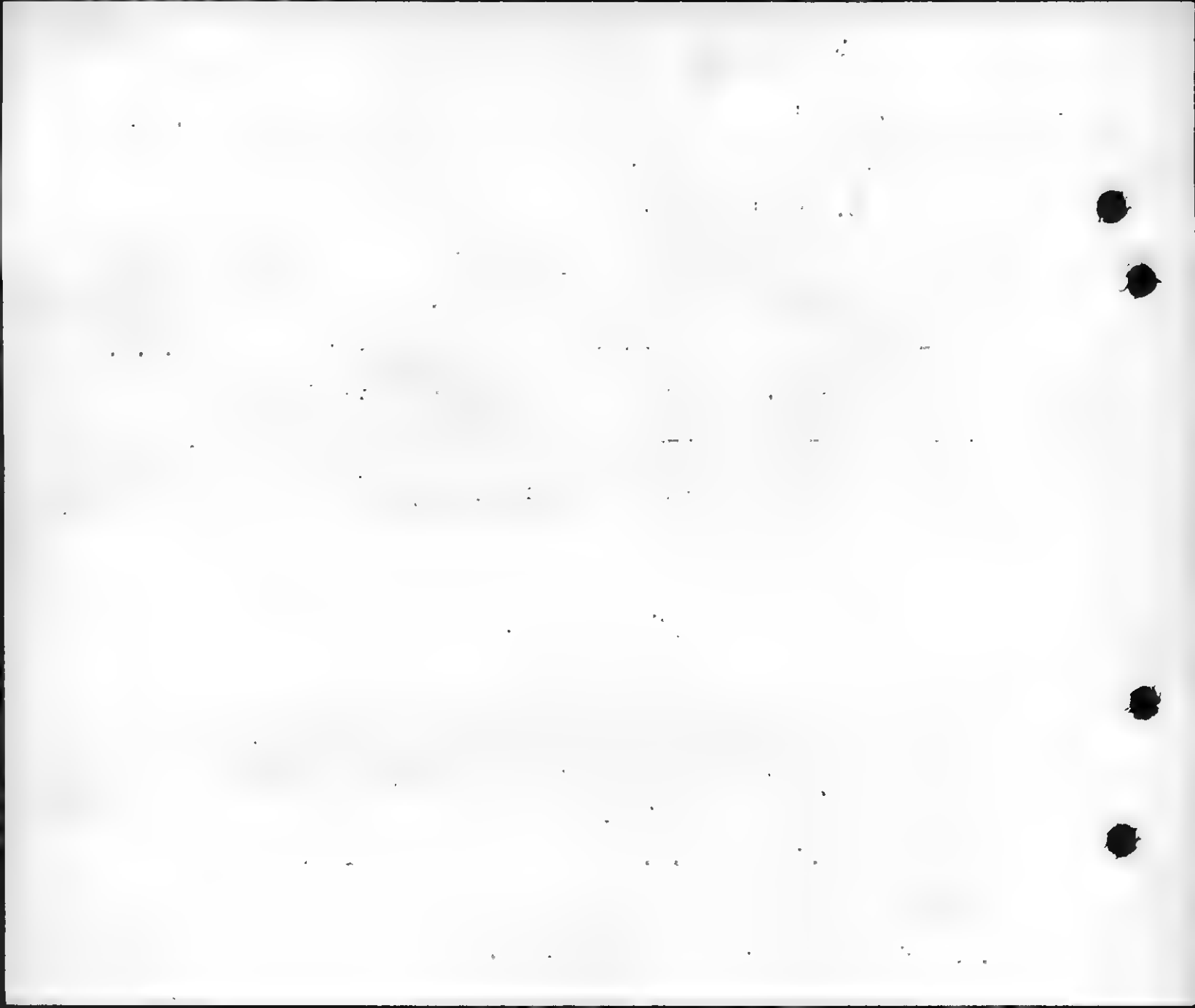
## 8359 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dale</b> Middle <b>Lee</b> Last <b>Keffer</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1959</b>
9. AGE (In years last birthday) yrs. <b>10</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hansel O. Keffer</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jacquillard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
INFORMANT <b>Mather</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordine septum defect</b> 754. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Primative birth (7 months)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 8, 1959</b> to <b>July 18, 1959</b> , that I last saw the deceased alive on <b>July 17, 1959</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7/19/59</b>			
ACTUAL SIGNATURE <b>P.J. Bear M.D.</b>		Great Mills. Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>	22d. LOCATION (City, town, or county) (State) <b>Great Mills, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 20 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in. The funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please place in the carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Abell</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>St. Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Abell</b> d. STREET ADDRESS <b>1d</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Francis Maddox</b>			4. DATE OF DEATH Month Day Year <b>July 30, 1959</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1909 50</b> yrs		9. AGE (In years last birthday) <b>50</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman, Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Legard Maddox</b>			14. MOTHER'S MAIDEN NAME <b>Mary N. Woodland</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-4748</b>		17. INFORMANT <b>Harold J. Maddox</b> Address <b>1222 Avenue, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X Congestive heart failure</b> DUE TO (b) <b>Primary CA of Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 wk - 3 month</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W.D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/31/59</b>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	
22d. LOCATION (City, town, or county) <b>Bushwood, Maryland</b>		22e. (State)		22f. (City, town, or county)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





8361

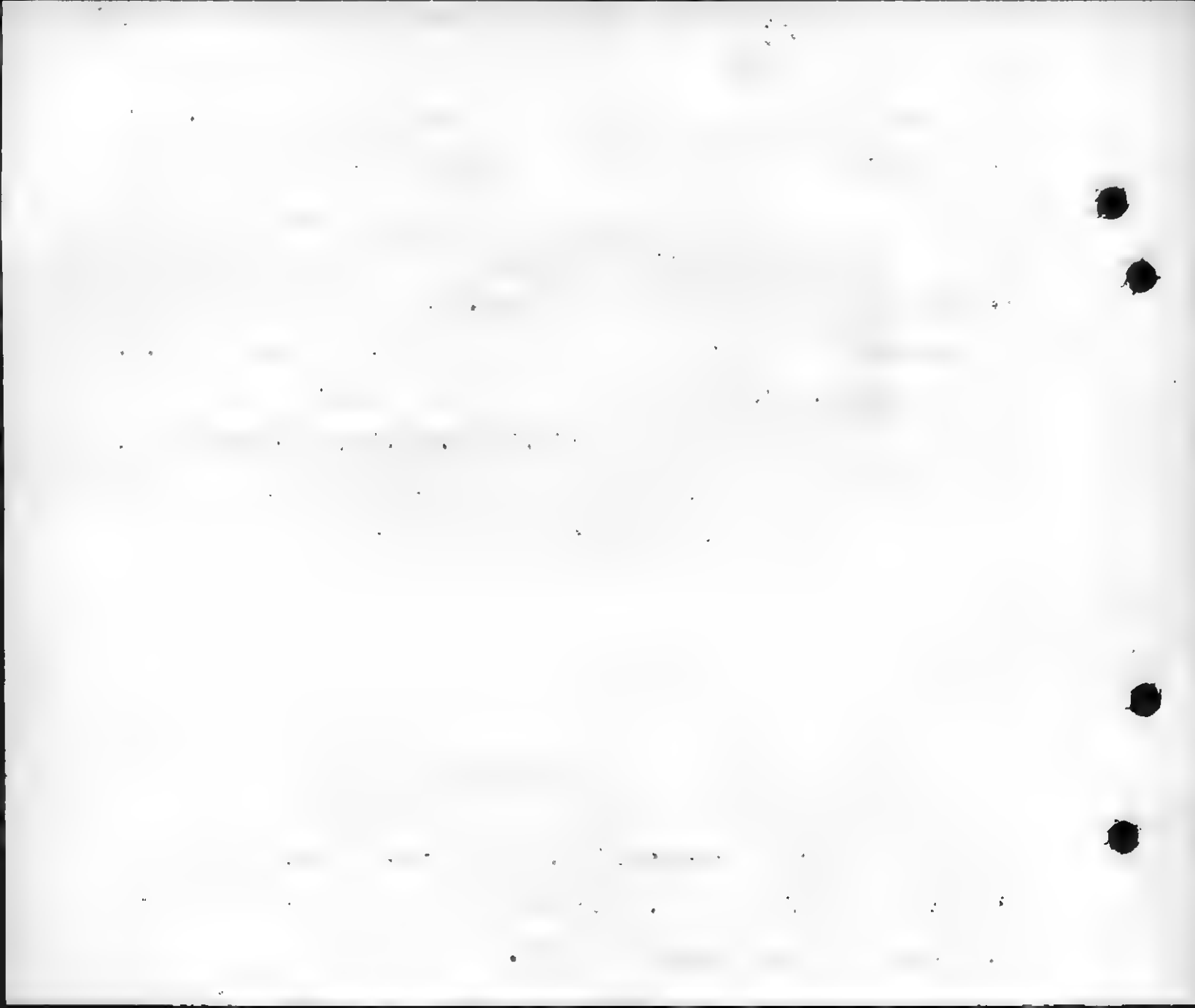
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>50yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Agnes Clarke Mattingly</b>		4. DATE OF DEATH Month Day Year <b>July 26, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Manley Clarke</b>		14. MOTHER'S MAIDEN NAME <b>Loretta Tucker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>William D. Mattingley</b>		Address <b>Leonardtwn, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary, acute Failure.</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute gastritis + Diabetes</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1957</b> to <b>July 26, 1959</b> that I last saw the deceased alive on <b>July 26, 1959</b> and that death occurred at <b>M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b> <b>Leonardtwn, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>	22d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital pending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG246 8-3-59 et

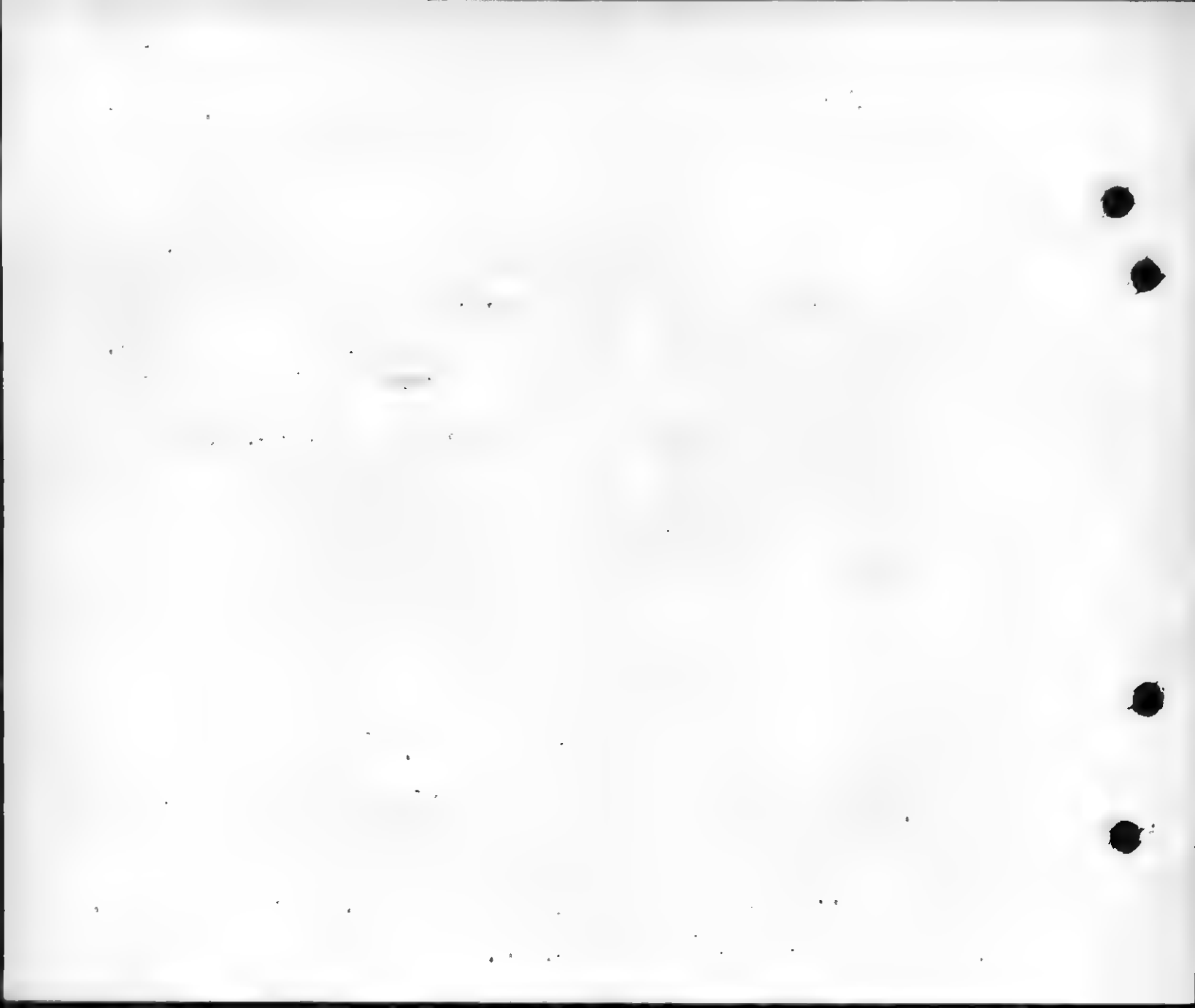
08342

8362

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. George Island</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mrs. Poe's Care Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Matthew</b> Last <b>Murphy</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hattan Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Cenie Molesworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Albert Murphy</b>		Address <b>Avenue, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>593X</b> DUE TO <b>Refractor</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 27</b> , 19 <b>59</b> , to <b>July 28</b> , 19 <b>59</b> that I last saw the deceased alive on <b>July 27</b> , 19 <b>59</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Leonardtown Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D. _____ PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Molesworth</b> ADDRESS <b>Molesworth Funeral Home Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 30 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18  
8363 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Yance</b> Last <b>Neal</b>		4. DATE OF DEATH Month <b>7</b> Day <b>- 2</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1873</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander Neal</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>-----</b>	
17. INFORMANT <b>Wm.R. Neal - Hague, Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive burnes (MASSIVE)</b> <b>7/6/59</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Residence completely destroyed by fire</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:15 a.m. 7/2/ 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Lexington Park, St. Marys, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm. D. Boyd, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>		DATE SIGNED <b>7/2/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>1st. Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Lexington Park, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Culver &amp; Howard</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

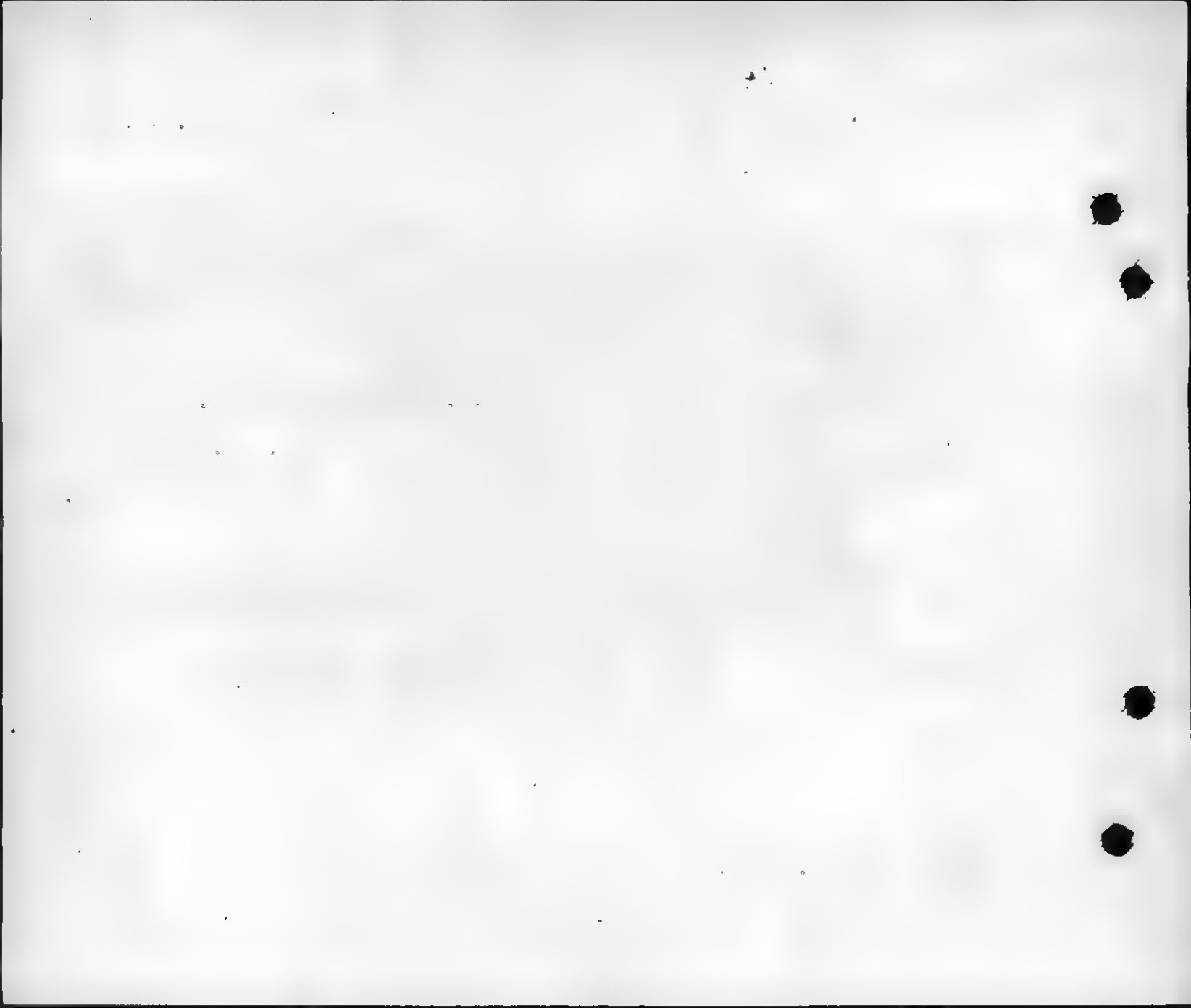
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8364

08344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Lexington Park, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) <b>Queenie Victoria Neal</b>		4. DATE OF DEATH <b>7 - 2 - 19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-1874</b>
9. AGE (in years last birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>-----</b>	
17. INFORMANT <b>Wm. R. Neal - Hague, Va.</b>		Address <b>Hague, Va.</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burnes ( Massive )</b> <b>9160</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>9160</b> (c) <b>9160</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9160</b> (b) <b>9160</b> (c) <b>9160</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Residence completely destroyed by fire</b>	
20c. TIME OF INJURY Month, Day, Year <b>7/2/59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <b>home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Lexington Park, St. Marys, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm. D. Boyd</b>		DATE SIGNED <b>7/2/59</b>	
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>1st. Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Lexington Park, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 14 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Julius L. K...</b>			





8365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN lb <b>16</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At her home - Leonardtown, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Owens</b>				4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 23, 1893</b>	
9. AGE (In years lost birthday) <b>66</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Philip Wilkinson</b>				14. MOTHER'S MAIDEN NAME <b>Frances Indiana Yates</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>Benjamin F. Owens Leonardtown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Lungs</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 16, 1959</b> to <b>July 30, 1959</b> that I last saw the deceased alive on <b>July 30, 1959</b> and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Leonardtown - Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D.				PHYSICIAN'S NAME (Type) <b>Charles Greenwell M. D. Leonardtown, Maryland</b>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>8-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Medley Neck, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> <b>Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



8366

## CERTIFICATE OF DEATH

06346

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Callaway</u>				TOWN <u>Callaway</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Rural		STREET ADDRESS		(If rural give location)	
				Rural			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles Roland Price</u>				<u>July 24 19 59</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>M</u>		<u>W</u>		<u>Married</u>		<u>1/26/1880</u>	
						9. AGE last birthday	
						<u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farming</u>		<u>farm owner</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Price</u>				<u>Irene Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Martha M. Price - Callaway, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Coronary Thrombosis</u>				<u>10/20/59</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 24, 1959</u> to <u>July 24, 1959</u> , that I last saw the deceased alive on <u>July 24, 1959</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Wm. H. Patrick</u>				DATE SIGNED <u>7/25/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Holy Face Cemetery</u>			
24. REC'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>JUL 28 '59</u>				ADDRESS <u>Great Mills, Md.</u>			
REGISTRAR'S SIGNATURE <u>Arthur S. Patrick</u>				P.B. Robinson - Leonardtown, Md.			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8367

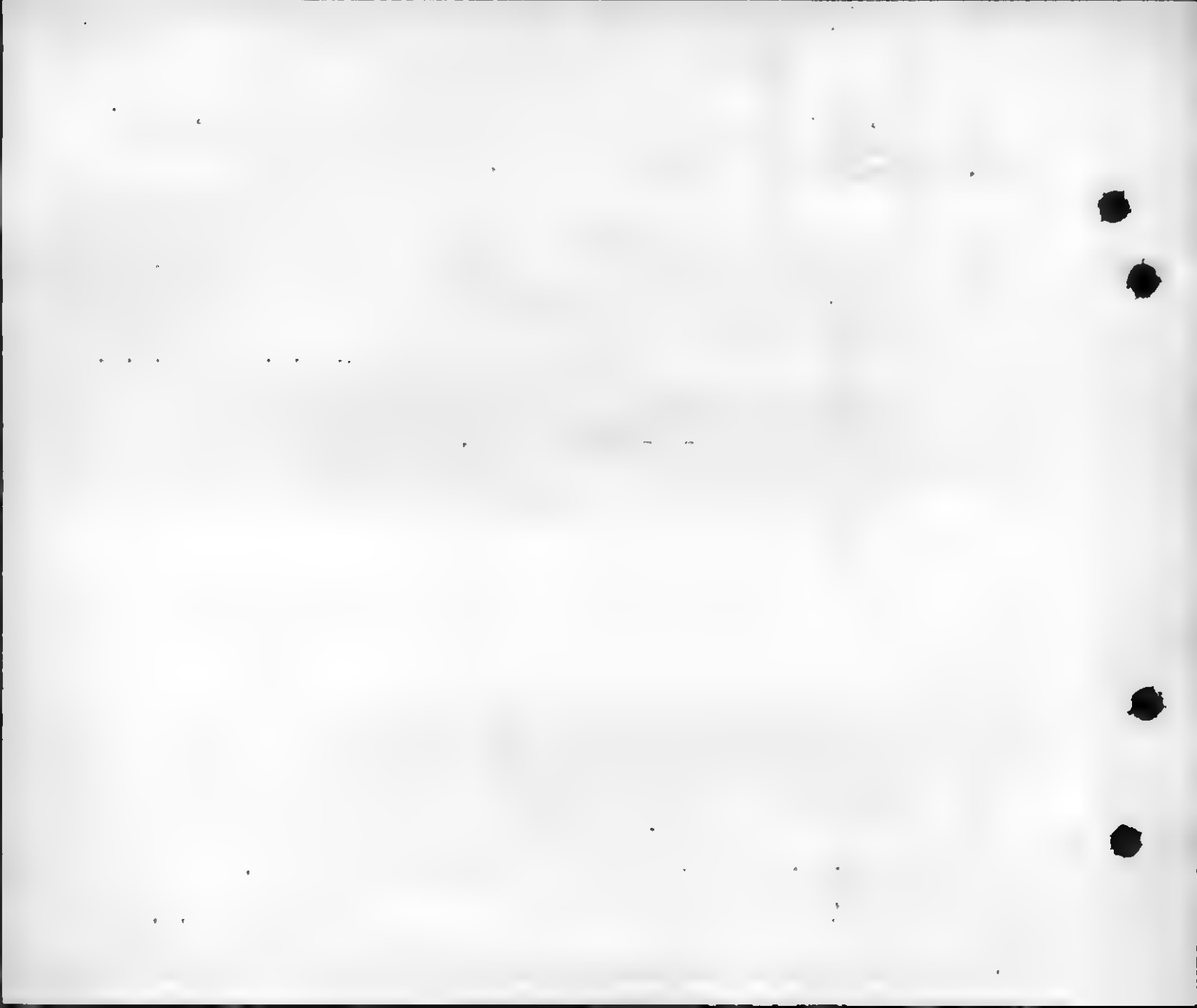
## CERTIFICATE OF DEATH

08347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. George Island</b>		c. LENGTH OF STAY IN 1b <b>18yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>L</b> Last <b>Wagner</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William W. Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Elizabeth Mater</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>107-03-3684</b>	
17. INFORMANT Address <b>Marie A. Wagner St. George Island, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cancer of left lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>16 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1957</b> to <b>July 3, 1959</b> , that I last saw the deceased alive on <b>July 2, 1959</b> , and that death occurred at <b>1700</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. J. Bean M. D.</b>		ADDRESS (Street, city or town, state) <b>Great Mills, Md.</b> DATE SIGNED <b>7/5/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown</b>		24a. REC'D BY REGISTRAR <b>Maryland</b> DATE <b>JUL 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. French</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8368 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Hollywood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b> <b>Hollywood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>			d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>John Francis Wheatley</b>			4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/3/1907</b>		9. AGE (in years last birthday) <b>51</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John Wheatley</b>		
14. MOTHER'S MAIDEN NAME <b>Annie L. Briscoe</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>213-16-2034</b>			17. INFORMANT <b>Hanah E. Wheatley - Hollywood, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gun shot wound of head.</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>stating the underlying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <b>instantly</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted gun shot wound of head.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> a.m. <b>7-23</b> 19 <b>59</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Hollywood</b>	(County) <b>St. Marys</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W.H. Patrick</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/24/59</b>	
EXAMINER'S NAME (Type) <b>Wm. H. Patrick, MD</b>		Ass. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Trinity</b>		22d. LOCATION (City, town, or county) (State) <b>St. Marys City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUL 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08349

Reg. Dist. No.

tem 18 Film 246 8-7-59 ams

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>			
c. LENGTH OF STAY IN 1b <b>10 Yrs.</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Ann</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>7</b> - Day <b>11</b> - Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 7, 1934</b>	
9. AGE (In years last birthday) <b>25</b> yrs.		IF UNDER 1 YEAR Months <b>25</b> Days <b>11</b> Hours <b>11</b> Min.		IF UNDER 24 HRS. Months <b>25</b> Days <b>11</b> Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>?????????????</b>				14. MOTHER'S MAIDEN NAME <b>Mary Adell Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>?</b>		17. INFORMANT Address <b>James Reed Ridge, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>292.6</b> IMMEDIATE CAUSE (a) <b>Sickle cell disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>292.6</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William Upchurch</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>		22d. LOCATION (City, town, or county) (State) <b>Great Mills Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley, Leonardtown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

4-8-51

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF BIRTH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]